HEALTH PROFESSIONS EDUCATION FOUNDATION
Giving Golden Opportunities

REGISTERED NURSE EDUCATION SCHOLARSHIP PROGRAM APPLICATION

TO BE COMPLETED BY APPLICANT: Please type or print clearly and legibly.

SECTION I – PERSONAL DATA

NAME: _____
FIRST MIDDLE LAST

MAILING ADDRESS: _____
STREET/P.O. BOX APARTMENT #

_____
CITY STATE COUNTY **(required)** ZIP CODE

PERMANENT ADDRESS: _____
STREET/P.O. BOX APARTMENT #

_____
CITY STATE COUNTY **(required)** ZIP CODE

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL ADDRESS: _____ CALIFORNIA DRIVER'S LICENSE/I.D. #: _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

SEX: ☐ MALE ☐ FEMALE ARE YOU A U.S. CITIZEN/PERMANENT RESIDENT? ☐ YES ☐ NO

ARE YOU A CALIFORNIA RESIDENT? ☐ YES ☐ NO

ARE YOU CURRENTLY UNDER ANY CONTRACT WITH THE FOUNDATION? ☐ YES CONTRACT # _____ ☐ NO

PLEASE PROVIDE THE NAME OF YOUR CALIFORNIA STATE SENATOR AND CALIFORNIA STATE ASSEMBLY MEMBER.

STATE SENATOR: _____ STATE ASSEMBLY MEMBER: _____

PLEASE INDICATE WHERE YOU RECEIVED YOUR APPLICATION:

☐ SCHOOL ☐ INTERNET ☐ FOUNDATION OFFICE

☐ OTHER (PLEASE SPECIFY)_____

PLEASE INDICATE YOUR ETHNIC BACKGROUND:

☐ African American ☐ Hispanic American ☐ Caucasian ☐ Other (Please Specify)_____

☐ Native American (Please Specify Tribal Affiliation and "Portion") _____

In addition to English, list any other languages you speak, read, or write fluently: _____

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

SECTION II - EDUCATION

——— I am currently enrolled in a baccalaureate degree nursing program in California.

——— I have been accepted to a baccalaureate degree nursing program for the _____ (Fall/Spring) Term _____ Year.

NAME OF NURSING SCHOOL: _____

SCHOOL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PROGRAM DIRECTOR: _____ SCHOOL PHONE: ( ) _____

YEAR ENTERED: _____ (MONTH/YEAR) EXPECTED GRADUATION DATE: _____ (MONTH/YEAR)

WILL YOU ATTEND SCHOOL FULLTIME: ☐ PART TIME: ☐

SECTION III – PERSONAL BACKGROUND

A. DESCRIBE YOUR CAREER GOALS

What kind of work would you like to do immediately after graduation?

What kind of work do you think you'll be doing in five years?

What is your vision of your professional future in ten years?

SECTION III – PERSONAL BACKGROUND cont.

B. LIST YOUR EMPLOYMENT HISTORY FOR THE PAST 10 YEARS

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Employer	City, State	Description of responsibilities

C. List any community service or professional activities within the past two years. Include work with community-based organizations, student organizations, civic committees, political associations, or religious organizations. At least one of the two required letters of recommendations should come from an individual who is qualified to verify and assess one of the community and or professional activities listed below. **Do not include experience for which you received academic credit..**

Dates (Mo/Yr – Mo/Yr)	Hours/Week	Position	Organization	City, State	Description of responsibilities

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

D. BACKGROUND

Residence History

Years	City, County, State	Specify if Rural, Urban, Suburban, Reservation, Inner City, etc…	Socioeconomic Level (Poor, Middle-class, etc…)	Predominant Ethnic Group in Community (White, Hispanic, African American, etc…)
Birth - 10				
10 – 20				
20 – 30				
30 - 40				
40 - Current				

DESCRIBE YOUR FAMILY STRUCTURE, ANY ADVERSE FAMILY CIRCUMSTANCES, AND CHALLENGES.

HOW IS YOUR BACKGROUND RELEVANT TO YOUR INTEREST IN PURSUING A NURSING CAREER?

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

SECTION IV – FINANCIAL NEED

(THIS FORM MUST ONLY BE COMPLETED IF YOU ARE NOT INCLUDING A COPY OF YOUR STUDENT AID REPORT)

Enter the total amount of the scholarship you are requesting (the maximum amount is **$8,000** per academic year)

Have you applied/do you plan to apply for financial aid from the college you will attend? ☐ Yes ☐ No

If not please indicate why. _____

Applicant's marital status: ☐ Married ☐ Unmarried Number of dependents other than self and spouse: _____ Age of dependents _____

List expenses and resources for the current calendar year:

Applicant's Educational Expenses:	
Tuition and mandatory fees	_____
Books and supplies	_____
Food	_____
Housing/Rent	_____
Utilities (Telephone, etc.)	_____
Transportation to classes/library	_____
Miscellaneous personal expense	_____
Child care expenses	_____
Subtotal – Educational Expenses	$_____

Applicant's Other Expenses:	
Transportation to work	_____
Automobile payments	_____
Automobile insurance	_____
Uncovered Medical Expenses	_____
Other (explain below)	_____
Subtotal – Other Expenses	$_____

Annual Resources: (If married, report total for self and spouse)	
Contribution from parents/relatives	_____
Savings	_____
Income earned from work	_____
Spousal/child support received	_____
Benefits	_____
Other untaxed income	_____
Subtotal – Resources	$_____

Expected Student Aid	
Federal Pell Grant	_____
Cal Grant	_____
Federal SEOG Award	_____
Campus Scholarships/Grants	_____
Other Scholarships/Grants	_____
Work/Study Award	_____
Federal Student Loans	_____
Campus Student Loans	_____
Other (list/explain below)	_____
Subtotal – Expected Student Aid	$_____

Below, please provide any needed explanation for the above items or additional information that supports your need for this scholarship.

If you have previously received or anticipate receiving any financial assistance that involves a service or work obligation, please list the type and amount of aid and obligation below.

HEALTH PROFESSIONS
EDUCATION FOUNDATION

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REGISTERED NURSE EDUCATION SCHOLARSHIP PROGRAM

GRADUATION DATE VERIFICATION FORM
MUST BE COMPLETED BY THE NURSING PROGRAM DIRECTOR

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered.

Applicant's Name: _____

School of Nursing: _____

Address: _____

Year Entered: _____ Expected Graduation Date: _____
Month/Year Month/Year

Please comment on the student's performance and potential for academic success

Name (Please Print) _____ **Title** _____

Signature _____ **Date** _____

Phone Number ( )_____

Please check one:

_____	I certify that I am the Nursing Program Director .
_____	I certify that I am authorized to sign this document on behalf of the Nursing Program Director.

CHECK LIST: DID YOU INCLUDE?

_____ ALL SECTIONS (Pages 1-7) OF THE APPLICATION

_____ GRADUATION DATE VERIFICATION FORM – **COMPLETED BY NURSING PROGRAM DIRECTOR OR AUTHORIZED PERSONNEL**

_____ **OFFICIAL** COLLEGE TRANSCRIPTS (AS STATED IN THE "APPLICATION REQUIREMENTS")

_____ 2 ORIGINAL LETTERS OF RECOMMENDATION ON LETTERHEAD (AS STATED IN THE "APPLICATION REQUIREMENTS")

_____ STUDENT AID REPORT (SAR) OR COMPLETE COPY OF PRIOR YEAR'S TAX RETURN, IF SAR NOT SUBMITTED.

NOTE: IT IS THE RESPONSIBILITY OF THE APPLICANT TO CONTACT THE FOUNDATION OFFICE BY 5:00 P.M. ON THE FINAL FILING DATE AT (800) 773-1669 TO VERIFY WHETHER HIS/HER APPLICATION WAS RECEIVED COMPLETE AND ACCURATE. THE FOUNDATION WILL NOT PLACE CALLS TO REQUEST ADDITIONAL INFORMATION OR CLARIFY ANY INFORMATION PROVIDED. IF AN INQUIRY IS MADE BY THE APPLICANT WHEREIN THE APPLICANT IS INFORMED THAT HIS/HER APPLICATION WAS INCOMPLETE, THE APPLICANT WILL HAVE 5 BUSINESS DAYS TO SUBMIT ORIGINAL VERSIONS OF ALL DOCUMENTS REQUIRED TO COMPLETE THE APPLICATION (COPIES AND FAXES WILL NOT BE ACCEPTED).

AND

PLEASE REMEMBER TO DUPLICATE APPLICATIONS PRIOR TO SUBMISSION. THE FOUNDATION WILL NOT RETURN ANY ORIGINALS OR COPIES OF THE APPLICATION PACKET.

I certify that all statements in this application are complete and accurate. I also authorize the Foundation to verify any information included on the application form and/or the attachments submitted with the application. I understand that falsification or discrepancies in documentation submitted will disqualify my application and the Board of Registered Nursing will be notified.

Signature: _____ Date: _____

INCOMPLETE OR LATE APPLICATION PACKETS WILL NOT BE EVALUATED

RETURN APPLICATION TO:
HEALTH PROFESSIONS EDUCATION FOUNDATION
1600 9th Street, Suite 436
Sacramento, CA 95814

FOR OFFICE USE ONLY

COMPLETE: YES _____ NO _____ IF NO, STATE REASON _____

RECEIVED BY: _____ (initials)